



DEPARTMENT OF THE NAVY

NAVAL HOSPITAL

BOX 788250

MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:

NAVHOSP29PALMSINST 1300.1

Code 0105

3 April 1995

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 1300.1

From: Commanding Officer

Subj: SUITABILITY PROCESSING FOR OVERSEAS ASSIGNMENTS OF NAVY
AND MARINE CORPS PERSONNEL AND ACCOMPANYING FAMILY MEMBERS

Ref: (a) OPNAVINST 1300.1A
(b) MCO P3000.1E
(c) Enlisted Transfer Manual, Chapter 4
(d) Officer Transfer Manual, Chapter 3
(e) BUMED message R 200129Z Jul 94
(f) NAVMEDCOMINST 1300.1C

Encl: (1) NAVPERS 1300/16, Report of Suitability for Overseas Assignment
(2) NAVMED 1300/1, Medical and Dental Overseas Screening Review for Active Duty and Dependents
(3) Special SF93, Report of Medical History for Overseas Assignment
(4) Special SF600, Suitability for Overseas Assignment
(5) Family Overseas Screening Instructions
(6) NAVPERS 1754/1/3/4, Exceptional Family Member Program Forms

1. Purpose. To delineate procedures to determine the suitability of Navy and Marine Corps personnel and their family members for overseas assignment.

2. Background

a. As required by references (a) through (d), active duty members in receipt of overseas transfer orders, including reservists serving under orders of 45 days or longer, must have an Overseas Screening (OSS). Navy family members will also be screened whether or not this will be an accompanied or unaccompanied tour. However, reference (e) states Marine Corps family members need not be screened if they choose not to accompany the active duty member and the length of tour is less than 24 months. Screening must be conducted and completed within 30 days of receipt of orders. If screening cannot be completed in this time frame, the member's command must send a message to Naval Military Personnel Command (or Commandant Marine Corps if Marine Corps personnel) to explain why it cannot be completed. The family unit should be screened together whenever possible. Civilian dental and medical screenings are authorized however,

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the Hospital Overseas Screening Coordinator will track these very carefully with assistance from a Naval Hospital physician.

b. Overseas duty is defined as duty performed while assigned to an activity permanently based outside the 48 contiguous United States (CONUS). Hawaii is exempt from overseas screening requirements. Several Navy duty stations in CONUS (such as Fallon, NV; Key West, FL; Winter Harbor, ME; and Adak, AK) have been designated "remote" duty stations by NMPC, and members in receipt of orders to these areas will receive screening identical to those transferring overseas. Additionally, some United States Naval Ship (USNS) vessels require screening prior to transfer even though they are homeported in CONUS.

c. Per reference (f), the Command Overseas Screening/Exceptional Family Member Program Coordinator will be appointed in writing and responsible for implementation and review of this program.

3. Action

a. Command Overseas Screening/Exceptional Family Member Program Coordinator shall:

(1) Ensure an Assistant Coordinator is named. For logistics, the Senior Independent Duty Corpsman at Military Sickcall is best located for this tasking. Also ensure appropriate liaison with all base-wide Battalion Aid Stations (BAS) concerning OSS.

(2) Ensure a Defense Enrollment Eligibility Reporting System (DEERS) check is performed on the member and family members. If DEERS check is unsatisfactory, refer member to Bldg. 1552 for DEERS update.

(3) Ensure physicians in Family Practice Department and Military Sickcall are trained in all aspects of OSS procedures. Ensure these personnel are assigned in writing by the Director, Medical Services.

(4) Schedule appointments via BAS Coordinators and the Assistant Coordinator for active duty members and family members, which will take place in two parts - a pre-screening and the actual appointment screenings (medical, dental and immunizations). The member will be instructed that the entire family MUST BE SCREENED TOGETHER at the same medical appointment. The member will be provided with enclosures (1) through (5) and will be instructed that the following records of document must be provided at all times of the screening process:

(a) Outpatient Health Records of member and all family members.

(b) Copies of care provided by civilian providers and narrative summaries of inpatient admissions in civilian facilities.

(c) Copy of overseas orders.

(5) Initiate enclosures (1) through (5).

(6) Provide a pre-screening of each medical record using enclosure (4). Physician, dental and immunization appointments will not be made until the pre-screening is complete. The following will also be initiated:

ACTIVE DUTY

- Physical, if out of date (members enlisting at age 18 or in age group 20-50, every 5 year requirement)
- G-6-PD, if not documented
- HIV, if not current (last 12 mo.)
- Sickle Cell, if not documented
- PAP/PELVIC, if not within 1 yr)
- Blood Type, if not documented
- Audiogram, if none documented

FAMILY MEMBER

- Physical, if medically indicated
- PAP/PELVIC, if medically indicated

(7) For a family member in need of special education or medically related services, initiate enclosure (6) for evaluation and enrollment in the Exceptional Family Member Program (EFMP) per reference (e). Both Marine Corps and Navy personnel are eligible for this program. NAVPERS 1754/3 should be completed by the family member's physician or other health care provider; NAVPERS 1754/4 should be completed by the school system, if applicable. If the screening physician concurs, all forms are mailed to the Naval Medical Center, San Diego EFM Program Coordinator by the Hospital EFM Coordinator.

(8) Contact the Base Family Advocacy Center to find out whether the member and family have an active case in progress. If an active case is under way, the Coordinator will liaison through the Hospital Command Family Advocacy Program Manager who will investigate the case to see if it may be a disqualifying factor.

(9) If any member is found unsuitable or has a potentially disqualifying problems, the Coordinator will establish communications with the prospective MTF responsible for providing care at the overseas station to determine capabilities. Messages should use International Classification of Diseases(ICD-9 codes) and describe examinee's medical history,

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condition, treatment requirements and whether the overseas facility can provide services for the condition. Ensure BUMED and NMPC or Commandant of the Marine Corps are information addressees. Message or PHONCON information shall be documented on the back of enclosure (4).

(10) Complete and sign Part I and II of enclosure (1) after:

(a) Enclosure (2) is completed and marked "suitable" in the dental and medical screens.

(b) Enclosure (3) has been completed and signed by the member and physician.

(c) Enclosure (4) has been checked off by Immunizations and Coordinator. Coordinator will date and sign.

(d) Upon receipt of positive return communication from the overseas MTF if potentially disqualifying messages have been generated.

(e) For possible Family Advocacy cases, word is received back from the Program Coordinator that the family is not disqualified.

(11) Photocopy all completed documents, including message traffic, and retain on file for 2 years. Originals of enclosures (2) through (4) shall be placed in the member's Health Record. Return the original enclosure (1) to the active duty member for processing of Part III by his parent command.

(12) Other responsibilities:

(a) Prepare standard forms and procedures to be used by this command for overseas screenings.

(b) Maintain communications with the Assistant Coordinator, Screening physicians, coordinators assigned at the various Battalion Aid Stations and the Command Family Advocacy Program Manager as well as the Base Family Advocacy Service.

(c) The Command Overseas Coordinator will also be assigned as the Exceptional Family Member Program manager and will assist all members and family members using the most current guidelines.

(d) Investigate and prepare responses to messages received by the command alleging deficient overseas screening.

(e) Periodically conduct audits of medical suitability screening and the screening process to maintain quality control.

b. Command Assistant Overseas Screening Exceptional Family Member Program Coordinator shall:

(1) Be assigned to the Hospital's Military Sickcall Facility. He/she will set up an Overseas Screening Process to accommodate ONLY active duty personnel from Headquarters Battalion and Marine Corps Communications and Electronics School who are transferring overseas unaccompanied. For immunizations, laboratory testing, audiograms and other types of testing, guidelines in reference (e) and enclosure (4) will be followed. If the member is transferring accompanied, the member will be told to contact the Hospital's Overseas Screening/Exceptional Family Member Program Coordinator to set up a pre-screening appointment for the member and family.

(2) The Assistant Coordinator's program will schedule pre-screening and medical/dental/immunization appointments and initiate enclosures (1) through (4). The pre-screen of the health record will be completed using enclosure (4).

(3) The active duty member must maintain all items discussed in para 3.a.(3) of this instruction throughout the screening process.

(4) The Assistant Coordinator will then use paragraph 3.a.(7), (8), (9), and (10) as guidelines to ensure a proper Overseas Screening is conducted.

c. Battalion Aid Stations on base (other than Military Sickcall). Responsibilities:

(1) BAS Overseas Screening Coordinators will continue to screen active duty members of their command if they are bachelors with no families or if the family members will not accompany the active duty member overseas.

(2) If the active duty member's family will accompany, they will be instructed to contact the Hospital Overseas Screening/Exceptional Family Member Program Coordinator via phone to set up an appointment. The family and service member will be screened and appropriate forms returned to the BAS Coordinator. This will satisfy the need that all members of the family be screened together.

d. Hospital Family Advocacy Program Manager's responsibilities:

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(1) Be assigned as the Hospital's Liaison to the base Family Advocacy Center.

(2) In the event a screening family has an active case with this program, investigate the family/case and determine whether it would be a disqualifying factor for overseas assignment. Relay this information to the OSS/EFM Program Coordinator or Assistant Coordinator.

e. Medical Screeners responsibilities:

(1) Screeners will be selected and assigned in writing by the Director, Medical Services.

(2) Ensure that the pre-screening has been completed prior to medical screening and all testing results returned.

(3) Interview sponsor and family members together. Review and complete SF93, Report of Medical History.

(4) Review current health status and medical history, including health care from civilian sources.

(5) Perform physical examinations (SF88) only if medically necessary or if routine exams are due by transfer date.

(6) Obtain a thorough medical history; address all positive answers on enclosure (3). Note any findings of physical exam, positive answers or disqualifying diseases or defects on enclosure (4). Any special medications will be listed and specialty evaluations will be arranged to clarify the individual's health status.

(7) Complete NAVPERS 1754/3 for any dependent newly or previously identified as having a chronic or long term condition. Refer the sponsor with 1754/3 to the Hospital's OSS/EFMP Coordinator.

(8) Identify pregnant service members or dependents unsuitable for travel to a location where obstetric care is not readily available. For service members, this includes ships. Any women who would arrive overseas in the third trimester of pregnancy is unsuitable until after delivery.

(9) Complete and sign Part I of enclosure (2) once all referrals, testing and possible message inquiries are complete.

4. Naval Hospital Staff Overseas Screening

a. Action

(1) Commanding Officer shall be the final approving authority for all overseas screenings.

(2) Head, Manpower Management shall:

(a) ensure all sections of the overseas screenings are completed prior to final signature by the Commanding Officer.

(b) keep the command's Overseas Screening/ Exceptional Family member Program Coordinator and Assistant apprised of all personnel and their family members requiring screenings.

(c) complete all service record entries and notifications to higher authority on member's suitability for overseas assignment.

(d) notify the Commanding Officer and per his/her consent hold orders in abeyance and notify BUPERS immediately if a member is found unsuitable for overseas assignment.

(3) Command Overseas Screening/ Exceptional family Member program Coordinator shall:

(a) coordinate with Staff Sickcall and Family Practice Department to ensure all active duty personnel and their family members are medically screened following the most current guidelines. All staff members will be told to report to the program coordinator for appropriate forms and instructions and to set-up a pre-screening date. After pre-screen, single staff members will be medically screened by Staff Sickcall and married staff members and their families will be medically screened by Family Practice.

(b) ensure all members have been screened by the Family Advocacy Program Manager prior to medical screening.

(c) ensure family members are screened if appropriate and enrolled in the EFM Program.

(d) if required, notify gaining commands of special required medical or educational needs. EFM Manager will hold screening in abeyance until receipt of response from the gaining command to ensure member's needs can be accommodated.

(e) assist geographic bachelors in ensuring family members are screened by contacting the nearest MTF to request assistance.

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(f) notify Manpower Management Department immediately if any member may be or is disqualified for overseas assignment.

(4) Family Advocacy Program Manager shall:

(a) screen all active duty and their families to ensure suitability for overseas assignment.

(b) not favorably endorse any screening if the member is found to be currently undergoing treatment or follow-up care for any substantiated family advocacy case.

(5) Department Heads shall:

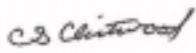
(a) complete the Part III, Command Review, of enclosure (1) and annotate on it any amplifying information that will assist the Commanding Officer in whether to approve/disapprove the overseas screening. The Command Review should not be conducted until all medical and dental screenings are complete.

(b) ensure member's signature is obtained on enclosure (1).

(c) forward all sections of completed screening to Head, Manpower Management. The entire process should be completed within 30 days of receipt of orders.

(6) Staff Members shall be responsible for notifying any screening official of any information that may disqualify themselves or their family members from serving overseas.

5. Applicability. Paragraph 4. of this instruction is applicable for all military personnel assigned to this Command.


C. S. CHITWOOD

Distribution:
List A

RCS BUPERS 1300-16			
REPORT OF SUITABILITY FOR OVERSEAS ASSIGNMENT			
MEMBER'S NAME	SSN	DATE	
PRESENT SHIP/STATION	UIC	OVERSEAS LOCATION	UIC
ISOLATED <input type="checkbox"/> YES <input type="checkbox"/> NO			
<p>PART I: COMMAND REVIEW – The purpose of the Command Review is to determine, via record review and personal interview, member and spouse/family member(s)' suitability for overseas duty/life in the assigned overseas location. (To be completed by Commanding Officer of transferring command.)</p> <p>YES NO</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has the member or any spouse/family member(s) previously been reassigned, prior to normal tour completion, due to their individual unsuitability?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If "YES," does the reason for previous reassignment still exist? (Explain in remarks section.)</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has the member previously been reassigned, prior to normal tour completion, due to unsuitability of member's family members?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If "YES," does the reason for previous reassignment still exist? (Explain in remarks section.)</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the member have sufficient OBLISERV to complete the prescribed tour? If "NO", have the member reenlist (NAVPERS 1070/601) or execute an extension (NAVPERS 1070/621) to incur sufficient OBLISERV, in accordance with, Enlisted Transfer Manual Chap. 3 Para. 3.07 "Time on Station and Retainability Policy". Page 13 entries for OBLISERV are prohibited. (OBLISERV MUST BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF ORDERS)</p> <p>a. If "YES," continue screening</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the member, spouse, or family member(s) have serious problems of indebtedness, credit loss or other financial problems which have not been reconciled with the creditor(s) or interested parties?</p> <p>5. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has the member's personal and or family financial health been evaluated WRT dept-to-income ratio, loss of a supplemental income (if applicable), and possible adverse impact imposed by the economy of the proposed overseas PDS? (NOTE: Dept-to-income ratio is calculated by dividing monthly net pay into the sum total of monthly recurring obligations (less mortgage/lease/rent).)</p> <p>a. If dept-to-income ratio is between 20-24%, determine the cause(s), and decide whether a waiver is practicable. If so, submit to BUPERS 40BB by message (info appropriate Detailer) IAW ETM para 4.012 for determination of suitability. If the debt-to-income ratio equals or exceeds 25%, the member is unsuitable for overseas assignment.</p> <p>6. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has the member, spouse or any family member(s) been convicted for any civilian offense(s) (civil or criminal) within the last 24 months (include pre-service time), or have any involvement in any ongoing civil or criminal action?</p> <p>7. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the member have a record of military offenses within the last 24 months which would preclude overseas assignment, e.g., two or more Captain's masts, several minor unexcused absences, a lengthy unauthorized absence: (One time major offenses in the current enlistment are considered disqualifying.)</p>			

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MEMBER'S NAME	SSN	DATE
<p>YES NO</p> <p>8. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the member or spouse/family member(s) have a record of any involvement with illegal drugs within the past 24 months? (Exceptions are recent enlistees who received an enlistment waiver or from whom no waiver was required for enlistment.)</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has the member or spouse/family member(s) been treated for substance use disorder within the past 24 months?</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has the member or spouse/family member(s) been treated for substance use disorder within the last 12 months? (Include pre-service time.)</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the member have a history of unsatisfactory or marginal performance within the past 24 months?</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If member is being assigned a <u>consecutive overseas tour</u> (in-place or otherwise), does the member have (during the current overseas tour): E1-E4, ITA of at least 3.0; E5-E6: ITA of at least 3.0 and "Promotable" promotion recommendation; E7-E9: no grades below 3.0 and "Promotable" promotion recommendation? See ENLTRANSMAN article 4.023 for waiver criteria (not applicable for officers.) (Personnel who have not met eligibility requirements for the next senior paygrade may be evaluated "Progressing Toward.")</p> <p>13. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are there family members residing with sponsor who have chronic medical, physical, and/or special education needs?</p> <p>- Enrolled in special education (on an Individualized Education Plan (IEP)) or being considered for placement?</p> <p>- Receiving early intervention services (on an Individualized Family Service Plan (IFSP)) or being considered for these services?</p> <p>- Have parents observed educational or developmental delays that are not yet formally identified?</p> <p>a. If "YES" to any of the above, refer member to the Exceptional Family Member Program Coordinator at the servicing MTF for possible EFM enrollment. Withhold final suitability Determination pending EFM category designation.</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Is the member or spouse/family member(s) involved in an open FAP (Family Advocacy Program) case that is still under investigation or for which treatment is still ongoing? (Any case/cases that has/have been adjudicated "Closed," shall not be considered disqualifying.)</p> <p>15. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Was the member's spouse previously a member of the armed forces? If so, and the characterization of separation was other than "honorable," explain in the remarks section.</p> <p>16. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does member/spouse have legal custody of all accompanying minor family members?</p> <p>17. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are any of the member's family members covered in a custody agreement? If "No," go to question 18.</p>		

MEMBER'S NAME	SSN	DATE
<p>YES NO</p> <p>a. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does agreement prevent removal of family members from CONUS without prior court approval or agreement between the interested party? If "NO," go to question 18.</p> <p>b. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has member obtained prior court approval of requisite agreement from other interested party for removal of family members from CONUS, if required by state law/ (<u>Please note:</u> Navy policy does not require a separate agreement if not required by state law.)</p> <p>18. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the member have two PRT failures (fitness or body composition) within the past three years and present a reasonable risk to fail a third cycle within the first year after transfer? (If there are two failures, but the command considers the member suitable, explain the reason(s) in detail in the remarks section.)</p> <p>19. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (Single parents/military couples with family members.) Have family member care requirements been met in accordance with OPNAVINST 1740.4 series?</p> <p>20. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> FOR PERSONNEL E-3 AND BELOW: Has the member been counselled that personnel in these paygrades, having family members, will not be assigned accompanied overseas duty? Members can be assigned unaccompanied based on readiness needs. (NOTE: Single E-3 and below who acquire (a) family member(s) en route and bring he/she/they along, will most probably return them at personal expense and serve the complete area tour unaccompanied.)</p> <p>21. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has member and adult dependents received "Level I" Antiterrorism – Force Protection (Level III for O-5/O-6 Commanding Officer Awareness Training), within 6 months of transferring, and recorded on Page 13? (Contact your local Family Service Center if training is not available at your current command)</p> <p>A check in any "YES" box above can result in non-endorsement of the member depending on (a) the reason for the "YES" check and (b) the nature of the overseas assignment.</p> <p>NOTE: If the reason(s) for previous reassignment in question 1 or 2 no longer exist(s), the question is counted as a "NO" check. A member with a combination of minor problems in the areas questioned above may be unsuitable as well as an individual with major offenses/problems on record.</p> <p>REMARKS: _____</p> <p>_____</p> <p>_____</p> <p>I, _____, am aware that the failure to divulge disqualifying information or amplifying information (medical/dental/personal) pertaining to the questions on this checklist may ultimately result in disciplinary action punishable under the UCMJ.</p>		
<p>_____ MEMBER (Signature)</p>	<p>_____ DATE</p>	<p>_____ MEMBER (Name, Rank/Rate)</p>
<p>_____ INTERVIEWER (Signature)</p>	<p>_____ DATE</p>	<p>_____ INTERVIEWER (Name, Rank/Rate) (CMND Title)</p>

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MEMBER'S NAME	SSN	DATE
<p>PART II: MEDICAL OVERSEAS SCREENING COORDINATOR'S SUMMARY.</p> <p>A. LIST OF PERSONS SCREENED:</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;">1. _____</div> <div style="width: 45%;">3. _____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;">2. _____</div> <div style="width: 45%;">4. _____</div> </div> <p>B. REVIEW CHECKLIST:</p> <div style="margin-left: 20px;"> <p>YES NO</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Has NAVMED 1300/1 been completed (along with supporting documents) for each individual listed above? (FOR OSSC: When satisfied that the 1300/1 and related documents are in order, ensure that they are filed in the appropriate military health record.)</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Is any chronic condition noted in the medical/dental screening?</p> <p style="margin-left: 20px;">a. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If "YES," has the receiving MTF's/ DTF's reply regarding suitability of the sponsor or family member been enclosed?</p> <p style="margin-left: 20px;">b. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If a chronic or special medical/educational problem exists, has Exceptional Family Member (EFM) Program enrollment been completed and category assigned? Hold suitability determination in Abeyance pending category or determination that enrollment not required.</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Are service member's HIV test results in military health record? Date of HIV test: _____</p> </div> <p>C. OVERSEAS SCREENING COORDINATOR'S CERTIFICATION:</p> <p style="margin-left: 20px;">An administrative review of the Medical and Dental Records of the individuals indicated above has been Accomplished. All conditions and/or illnesses have been addressed and steps have been taken to Ensure that the capabilities are available at the prospective Medical/Dental Treatment Facility.</p> <div style="display: flex; justify-content: space-between; margin-top: 30px;"> <div style="width: 30%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Coordinator's Signature </div> <div style="width: 20%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date </div> <div style="width: 30%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Print Coordinator's Name </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 30px;"> <div style="width: 30%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Coordinator's Duty Station </div> <div style="width: 30%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> DSN Phone No. </div> </div>		

MEMBER'S NAME

SSN

DATE

PART III: RECOMMENDATION OF COMMANDING OFFICER (OR OIC) OF MEDICAL TREATMENT FACILITY

Based on the information available as a result of screening and on the capabilities of the Medical/Dental Treatment Facility in the area of assignment to which ordered, the following recommendation is forwarded:

YES NO

1. ☐ ☐ ☐ Is the service member recommended for this overseas assignment?

If "NO," state reasons:

2. ☐ ☐ ☐ Regardless of whether or not this is to be an accompanied tour, are all family members (spouse/family member(s)) recommended for this overseas assignment?

If "No," state reasons:

Medical Treatment Facility: _____

Signature of CO/OIC or Designee
of Medical Treatment Facility

Date

Print name of CO/OIC or Designee
of Medical Treatment Facility

PART IV: COMMANDING OFFICER'S ENDORSEMENT

On the basis of all available information, I endorse/I do not endorse (circle one) the member's orders for the overseas Assignment.

Commanding Officer (Signature)

Date

Commanding Officer (Name, Rank)

PRIVACY ACT STATEMENT: The authority to request this information is contained in 5 USC301 Departmental regulations. The information will be used to assist officials and employees of the Department of the Navy in determining your future duty assignment. Completion of the form is mandatory except for duty and home phone Numbers; failure to provide required information may result in delay in response to or disapproval of your request.

**MEDICAL AND DENTAL OVERSEAS SCREENING REVIEW
FOR ACTIVE DUTY OR DEPENDENT**

EXAMINEE	GRADE, RATE, OR DEPENDENT	SSN	FMP
SPONSOR'S NAME (IF APPLICABLE)	PRESENT DUTY STATION	NEXT DUTY STATION	NEXT UIC

PART I: MEDICAL SCREENING. The purpose of the medical screening (the review of military/civilian medical records and history; and the interview with the examinee) is to assess the physical and mental suitability for transfer to overseas areas where access to medical facilities may be limited or where capabilities do not exist in certain medical specialties. SF93, Report of Medical History, will be completed during the interview for every examinee and attached to NAVMED 1300/1.

1. Are there any chronic medical or mental conditions requiring routine or continuing access to care or access to specialized medical care?

- () NO - Proceed to next question.
- () YES - List all chronic medical or mental conditions. Indicate examinee's treatment requirements for all conditions. For dependent, complete NAVPERS 1754/3 (Form M), Rev. 5-90. Refer sponsor to exceptional Family Member (EFM) Coordinator after medical screening.

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2. (For school age child) Has dependent ever been placed in special education classes or received an individualized Education Program (IEP) at school?

- () NO - Proceed to question 3.
 () YES - Sponsor should have NAVPERS 1754/3 (Form), (Rev. 5-90), reviewed or completed by screener and noted under question 1 above. Refer child to Exceptional Family Member (EFM) Coordinator after medical screening.

3. (For Female) Is the examinee pregnant?

- () NO - Proceed to question 4.
 () YES - Complete the following:
- If complications are anticipated, ensure they are indicated in question 1 above.
 - Are obstetrical and pediatric care readily available at assignment location?
- () NO - Proceed to question 5 and find examinee unsuitable for this assignment.
 () YES - Complete next question.
- Will the examinee arrive at the overseas location during the third trimester of pregnancy?
- () NO - Proceed to question 4.
 () YES - Proceed to question 5 and find examinee unsuitable for this assignment.

4. If question 1, 2, or 3 is answered YES, receiving MTF must be queried about local capabilities and transportation accessibility for required services. Attach reply to this form.

5. What is your recommendation on examinee's suitability for this assignment?

Suitable () Unsuitable ()

_____		or	_____	
Military MTF: Privileged Practitioner's Signature			Civilian facility: Signature of Examining Physician	
_____			_____	
Name/Rank or Grade (Print)			Physician's Name (Print)	
_____			_____	
SSN			Address	
_____			_____	
MTF or Duty Station			City / State / Zip Code	
_____			_____	
_____	_____		_____	_____
Phone No.	Date		Phone No.	Date

PART II: DENTAL SCREENING. The purpose of the dental screening examination and dental record Review is to determine if the dental health of the examinee is suitable for assignment to overseas area's where Access to dental care may be limited or where the capability for dental care within a military facility does not Exist. Complete SF 603, Dental Health Record, and NAVMED 6600/3, Dental Health Questionnaire, and Attach to NAVMED 1300/1.

1. Does the examinee have any acute or chronic dental conditions (including active orthodontics) requiring routine or continuing access to care or access to specialized dental care?

- () NO - Proceed to question 4.
() YES - Proceed to next question.

2. List all acute or chronic dental conditions or illnesses as noted in the (a) dental record review, (b) dental examination, and (c) interview with the examinee:

3. If examinee's condition(s) will make him/her unsuitable for this assignment and can be corrected, do not complete this form until treatment is completed and/or examinee is found suitable/unsuitable. Arrange for treatment at your clinic or elsewhere as appropriate. Can treatment be completed prior to transfer date?

- () NO - Provide servicemember's command with estimated date of completion of treatment and overseas screening.
() YES - Schedule treatment and completion of screening.

4. What is your recommendation on examinee's suitability for this assignment?

Suitable () Unsuitable ()

_____ or _____	
Military DTF: Examining Dentist's Signature	Civilian facility: Examining Dentist's Signature

Name/Rank or Grade (Print)	Dentist Name (Print)

SSN	Dentist's Address

DTF or Duty Station	City / State

Phone No. _____	Phone No. _____
Date _____	Date _____


REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME – FIRST NAME – MIDDLE NAME						2. SOCIAL SECURITY OR IDENTIFICATION NO.					
3. HOME ADDRESS (No. STREET or RFD, city or town, state, and ZIP CODE)						4. Position (title, grade, component)					
5. PURPOSE OF EXAMINATION				6. DATE OF EXAMINATION		7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)					
<p>8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, is complaint exists)</p> <p>I AM / AM NOT IN GOOD HEALTH I DO / DO NOT HAVE ALLERGIES I DO / DO NOT TAKE MEDICATIONS, LIST MEDICATIONS:</p>											
9. HAVE YOU EVER (Please check each item)						10. DO YOU (Please check each item)					
YES		(Check each item)				YES		NO		(Check each item)	
		Lived with anyone who had tuberculosis								Wear glasses or contact lenses	
		Coughed up blood								Have vision in both eyes	
		Bled excessively after injury or tooth extraction								Wear a hearing aid	
		Attempted suicide								Stutter or stammer habitually	
		Been a sleepwalker								Wear a brace or back support	
11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)											
YES		(Check each item)		YES		NO		DON'T KNOW		(Check each item)	
		Scarlet fever, erysipelas								Cramps in your legs	
		Rheumatic fever								Frequent indigestion	
		Swollen or painful joints								Stomach, liver, or intestinal trouble	
		Frequent or severe headache								Gall bladder trouble or gallstones	
		Dizziness or fainting spells								Jaundice or hepatitis	
		Eye trouble								Adverse reaction to serum, drug, or medicine	
		Ear, nose, or throat trouble								Car, train, sea, or air sickness	
		Hearing loss								Broken bones	
		Chronic or frequent colds								Tumor, growth, cyst, cancer	
		Severe tooth or gum trouble								Rupture/hernia	
		Sinusitis								Piles or rectal disease	
		Hay Fever								Frequent or painful urination	
		Head injury								Bed wetting since age 12	
		Skin disease								Kidney stone or blood in urine	
		Thyroid trouble								Sugar or albumin in urine	
		Tuberculosis								VD-Syphilis, gonorrhea, etc.	
		Asthma								Recent gain or loss of weight	
		Shortness of breath								Arthritis, Rheumatism, or Bursitis	
		Pain or pressure in chest								Bone, joint or other deformity	
		Chronic cough								Lameness	
		Palpitation or pounding heart								Loss of finger or toe	
		Heart trouble								Painful or "trick" shoulder or elbow	
13. WHAT IS YOUR USUAL OCCUPATION?						14. ARE YOU (Check one)					
						<input type="checkbox"/> Right handed <input type="checkbox"/> Left Handed					

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YES	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT		
	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc. B. Inability to perform certain motions. C. Inability to assume certain positions. D. Other medical reasons (If yes, give reasons.)		
	16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		
	17. Have you ever been denied life insurance? (If yes, state reason and give details.)		
	18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)		
	19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
	20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)		
	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		
	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)		
	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom and what amount, when, why.)		
I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.			
TYPED OR PRINTED NAME OF EXAMINEE		SIGNATURE	
NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY." 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)			
TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER		DATE	SIGNATURE
			NUMBER OF ATTACHED SHEETS

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE				
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>					
	NAVAL HOSPITAL TWENTYNINE PALMS, CALIFORNIA					
	OVERSEAS SCREENING COMPLETED THIS DATE:					
	THE FOLLOWING ITEMS HAVE BEEN COMPLETED AND VERIFIED FOLLOWING NAVMEDCOMINST 1300.1C					
	(1) TRANSFER DATE:					
	(2) PRE-SCREENING COMPLETED THIS DATE:					
	(3) HEALTH RECORD AVAILABLE FOR REVIEW:					
	(4) SF 93 COMPLETED:					
	(5) CIVILIAN RECORDS AVAILABLE FOR REVIEW:					
	PAP/PELVIC EXAM IF REQUIRED: (6) ACTIVE DUTY WITHIN 12 MONTHS OF DATE OF TRANSFER:					
	(7) IMMUNIZATIONS VERIFIED:					
	DEERS CHECK PERFORMMED: (8) <u>ACTIVE DUTY ONLY</u> :					
	PHYSICAL EXAM IF REQUIRED:					
	G6PD TESTING DOCUMENTED:					
	BLOOD TESTING DOCUMENTED:					
	AUDIOGRAM, IF ONE NOT ON FILE:					
	SICKLE CELL TESTING DOCUMENTED:					
	HIV TESTING DOCUMENTED: (WITHIN 12 MONTHS OF TRANSFER)		DATE:	RESULTS:		
	EXCEPTIONAL FAMILY MEMBER CHECK:		DATE:			
	FAMILY ADVOCACY CHECK:		DATE:			
	OVERSEAS SCREENING COORDINATOR		SIGNATURE			
PATIENT'S IDENTIFICATION <i>(Use this space for Mechanical Imprint)</i>		RECORDS MAINTAINED AT:				
		PATIENT'S NAME <i>(Last, First, Middle initial)</i>				SEX
		RELATIONSHIP TO SPONSOR		STATUS	RANK/ GRADE	
		SPONSOR'S NAME			ORGANIZATION	
		DEPART./SERVICE	SSN/IDENTIFICATION NO.			DATE OF BIRTH

ORIGINATOR:

OVERSEAS SCREENING INSTRUCTIONS

ACTIVE DUTY MEMBERS WITH ACCOMPANYING FAMILIES

Overseas Screenings (OSS) are required for all active duty members in receipt of overseas orders. Family members are also required to screen if they will accompany the active duty member. ALL FAMILY MEMBERS ARE REQUIRED TO BE SCREENED TOGETHER AT THE SAME MEDICAL APPOINTMENT WITH THE ACTIVE DUTY MEMBER.

1. You now have the appropriate forms and instructions to complete your overseas screening procedure. The basic steps are as follows:

a. Complete all forms as described in paragraph 3. of these instructions.

b. Active duty member call the Hospital Overseas Screening Coordinator for a "pre-screening appointment". Do not attempt to make any appointments until the PRE-SCREENING is complete.

c. Active duty member ONLY required at "pre-screening". Items to bring to the appointment:

(1) A copy of your transfer orders.

(2) Yours and all family member's Health Record.

(3) Copies of any civilian care received by you or your family members.

(4) Completed overseas screening forms for all members.

d. At the "pre-screening" all Health Records will be screened for various testing, lab work, pelvic exams, etc. Completed OSS forms will be reviewed. A check with the base Family Advocacy Center and an opportunity to enroll in the Exceptional Family Member Program (if necessary) will be available.

e. After the "pre-screening", the active member and family can make medical, dental and immunization appointments.

(1) Dental does not schedule Overseas Screening appointments by phone. Go to the Dental Clinic and they will instruct you when to come in with your entire family for screening. Ensure you take Dental records, all forms and record of any civilian dental care. If you and family are geographically separated, civilian dental checks are authorized.

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(2) Call the Central Appointment Desk at 830-2886 and arrange an Overseas Screening medical appointment for all family members in the Family Practice Department. Take all medical records, civilian care record and forms to the appointment. The entire family should go to the appointment together. Try to arrange the appointment for a Monday, Tuesday or Wednesday so you can also have your immunization records screened. Immunizations is a walk-in clinic located near Family Practice Clinic. If you go there on a Thursday or Friday and you need a PPD (Tuberculin test), it must be evaluated 48 hours later and the clinic is closed on week-ends.

f. Once Dental, Medical and Immunization appointments are completed, call the Overseas Screening Coordinator and arrange for an appointment. Only the active duty member need come to this appointment. All paperwork will be reviewed and signed off and returned to the appropriate health records. The "Report for Suitability for Overseas Assignment will be returned to the member for processing by his/her unit.

2. If you have any questions during this process, you may reach the Hospital Overseas Screening Coordinator at _____.

3. Overseas Screening Forms Instructions.

a. NAVPERS 1300/16, Report of Suitability for Overseas Assignment. You need one form for the entire family. Complete the top portion and Part I. A., LIST OF PERSONS SCREENED.

b. NAVMED 1300/1, Medical and Dental Overseas Screening Review for Active Duty or Dependent. You need one form for each member of the family.

(1) Complete the top portion on page 1. up to Part I. The rest of the form will be completed by physician or dentist.

c. SF 93, Report of Medical History. Need one for each family member.

(1) Fill out sections 1 thru 14. Note, Blk 2 is active duty members SSN. Blk 5 in OVERSEAS SCREENING. Blk 7 in NAVAL HOSPITAL TWENTYNINE PALMS CA

(2) Fill in sections 15 thru 24 on back page.

(3) Type or Print name of examinee. Sign the form in SIGNATURE block. Parents may sign for children.

d. SF 600, Chronological Record of Medical Care. You need one form for each member. Complete the "Patient Identification" section.

Enclosure (5)

INSTRUCTIONS FOR ENROLLMENT IN THE EFM PROGRAM

The EFM Program is a mandatory requirement per OPNAVINST 1754.2 to Identify family members with special medical or special education Needs. The program aids detailers and monitors in assigning service members to areas where special needs will be met. For additional information, review OFF/ENL TRANSFER MANUALS, contact the medical EFM Coordinator or your command point of contact.

GENERAL ENROLLMENT GUIDELINES:

- * To qualify for this program, family members must be enrolled in DEERS and residing with the sponsor.
- * The family member must have a chronic illness or physical/educational disability required long term care and monitoring.
- * NAVPERS 1754/1 EFM Application is completed by sponsor/spouse.
- * NAVPERS 1754/3 Functional Medical Summary is completed by the family member's military or civilian physician, including all children being enrolled with special education requirements.
- * NAVPERS 1754/4 Special Education Worksheet is completed by a school official when special education exceeds 20% of school time or when the Individual Education Plan (IEP) indicates occupational/physical therapy, speech/language or psychological services is/are required. Attach current IEP or ISFP.
- * Special Education endorsement is required for all 5-18 yrs old.
- * Sponsor must retain a copy of EFM forms for update requirements.
- * Give completed forms to EFM Coordinator or forward directly to:

EFM Central Screening Comm or
Commanding Officer
Naval Hospital (Code 0505A)
Portsmouth, VA 23708-5000
(804) 398-5833

EFM Central Screening Comm
Commanding Officer
Naval Hospital (Code CGH)
San Diego, CA 92134-5000
(619) 532-7291

- * For questions or inquiries, please call:

Exceptional Family Member Program
Bureau of Naval Personnel (Pers-662D8)
Washington, DC 20370-5662
Dsn: 223-3308; Commercial: (703) 693-3308

Exceptional Family Members Program
Commandant Marine Corps (Code MHF)
Washington, DC 20380-0001
DSN: 226-2046; Commercial: (703) 696-2049; FAX: (703) 696-1143

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EXCEPTIONAL FAMILY MEMBER (EFM) PROGRAM APPLICATION

PRIVACY ACT STATEMENT: The authority to request the following information is contained in 5 USC 301, 10 USC 3012, 20 USC 921-932, Public Law 94-142, Public Law 95-561, DoD Instruction 1342.12, DoD Directive 1342.13, and Executive Order No. 9397. This information is requested to allow enrollment of a sponsor and his or her exceptional family member into the EFM program. The information will be used to assist officials of the Department of the Navy in assignment of personnel with an exceptional family member to duty stations with the Special education and health-related services necessary and available to meet their needs. Disclosure of this Information requested from the sponsor is mandatory.

NOTE: Refer to OPNAVINST 1754.2A for application procedures and additional information

☐ First Application ☐ Updated Application

SPONSOR INFORMATION

NAME: (LAST, FIRST M.)		SSN:	RANK/RATE:
BRANCH OF SERVICE:	DESIG / NEC / MOS:	PRD:	EAOS:
HOME ADDRESS:			HOME PHONE: (Area code & number)
DUTY STATION ADDRESS:			DUTY PHONE: (COMMERCIAL)
			DSN:
ARE YOU CURRENTLY ON HUMANITARIAN ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			
IS YOUR SPOUSE ON ACTIVE DUTY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YES, NAME		RANK / RATE	SSN:

EXCEPTIONAL FAMILY MEMBER INFORMATION

NAME: (LAST, FIRST M.)		RELATIONSHIP TO SPONSOR:	
DATE OF BIRTH: (YY/MM/DD)	HEALTH CARE PROVIDER: (PLEASE CHECK ONE)		
	MILITARY <input type="checkbox"/>	CHAMPUS <input type="checkbox"/>	STATE <input type="checkbox"/> OTHER <input type="checkbox"/>
IS EFM ENROLLED IN DEERS: YES <input type="checkbox"/> NO <input type="checkbox"/>		UNDER WHAT SSN:	

IF EFM DOES NOT RESIDE WITH SPONSOR, PROVIDE ADDRESS & EXPLAIN:

SIGNATURES

SPONSOR SIGNATURE:	DATE:
EFM MEDICAL COORDINATOR NAME:	DATE:
MEDICAL DEPARTMENT ADDRESS:	PHONE:

FUNCTIONAL MEDICAL SUMMARY

RELEASE AUTHORIZATION

PHYSICIAN INFORMATION

EFM'S PHYSICIAN:

PHYSICIAN'S ADDRESS:

TELEPHONE: (Commercial)

DSN:

SPONSOR INFORMATION

I hereby authorize the above named physician or his or her agent to release information in this Functional Medical Summary for the family member named below to EFM program officials for the purpose of evaluating and determining Necessary health-related services.

(Name of Exceptional Family Member)

Relationship to Sponsor)

SPONSOR SIGNATURE: _____ DATE _____

NOTE: *Sponsor must also certify the completion of the Functional Medical Summary on the last page.*

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FUNCTIONAL MEDICAL SUMMARY**PART I**

NOTE: Physician, please fill this out as completely and accurately as possible using ICD-9 or DSMIII.

CURRENT ACTIVE DIAGNOSES	ICD or DSM	SEVERITY: A – MILD, B – MODERATE, C – SEVERE	FREQUENCY OF INPATIENT CARE

PHYSICIAN PLEASE PROVIDE: Prognosis, expected length of treatment, required participation of family members, and if treatment is on – going.

PART II**ARTIFICIAL OPENINGS/SHUNTS:**

NONE	GASTROSTOMY (V44.1)	TRACHEOSTOMY (V44.0)
ILEOSTOMY (V44.2)	CYSTOTOMY (V44.3)	COLOSTOMY (V44.3)
VP SHUNT (V45.2)	OTHER:	

PART III

List the MEDICATIONS AND DOSAGES that the patient requires on a routine basis including Chemotherapy, radiation therapy, or blood products.

PART IVARCHITECTURAL CONSIDERATIONS: ☐ LIMITED STEPS ☐ COMPLETE WHEELCHAIR ACCESSIBILITY

FUNCTIONAL MEDICAL SUMMARY

PART V

MINIMUM HEALTH CARE SPECIALTY required for care. (check appropriate box)

(SPECIFY IF PEDIATRICS SUB-SPECIALIST)	6-12 MONTHS	3-4 MONTHS	MONTHLY	WEEKLY
ALLERGIST				
AUDIOLOGIST				
CARDIOLOGIST				
DERMATOLOGIST				
DEVELOPMENTAL PEDIATRICIAN				
DIETARY/NUTRITION SPECIALIST				
ENDOCRINOLOGIST				
FAMILY PRACTITIONER				
GASTROENTEROLOGIST				
GENERAL MEDICAL OFFICER				
GYNECOLOGIST				
HEMATOLOGIST/ONCOLOGIST				
IMMUNOLOGIST				
NEPHROLOGIST				
NEUROLOGIST				
NUCLEAR MEDICAL PHYSICIAN				
OCCUPATIONAL THERAPIST				
OPHTHALMOLOGIST				
ORTHODONTIST				
ORTHOPEDIC SURGEON				
OTORHINOLARYNGOLOGIST				
PEDIATRICIAN				
PODODONTIST				
PHYSIATRIST				
PHYSICAL THERAPIST				
PODIATRIST				
PHYSIATRIST				
PHYSICAL THERAPIST				
RHEUMATOLOGIST				
SOCIAL WORKER				
SPEECH PATHOLOGIST				
SURGEON				
TRANSPLANT TEAM				
UROLOGIST				

FUNCTIONAL MEDICAL SUMMARY (cont'd)

PART VI

THERAPY/SPECIAL SERVICE REQUIREMENTS

GENERAL SERVICES REQUIRED:		Physical therapy
	Social work services	Program for visually impaired
	Occupational therapy	Community health nurse services
	APNEA monitor home program	Early intervention program
	Cognitive enrichment program	Durable medical equipment
SPEECH/LANGUAGE / AUDIOLOGY SERVICES:		Speech/language impairments
	Total communication (includes signing for hearing persons)	Augmentative communication (uses communication devices)
	Hearing impaired (include signing/hearing aids/assistive listening devices)	Other
PART VII	DESCRIBE surgery or treatment likely within the next 3 years with the approximate date. List other problems or family circumstances that should be considered in the assignment of the sponsor. Attach medical statement.	

PHYSICIAN NAME: (PRINTED)		SIGNATURE/ DATE
ADDRESS:		PHONE NUMBER:
I certify that I have reviewed the above medical information, and that it is complete and correct to the best of my knowledge.		
SPONSOR SIGNATURE: _____ DATE: _____		

SPECIAL EDUCATION WORKSHEET (cont'd)

Services required:

	Cognitive enrichment program		Program for visually impaired
	Community health nurse services		Program for oral motor therapy
	Social work services		Occupational therapy
	APNEA monitor home program		Physical therapy

Standard therapy required for:

	Speech/language impairments		Hearing impaired (includes signing)
	Total communication (includes signing for hearing		Augmentative communication (uses communication
	Alaryngeal speech (rehabilitation after laryngeal sur		Other (specify)

Please indicate any other special requirements of the student.

- ☐ YES ☐ NO Is this exceptional family member one of the rare few for whom a move out of his /her current location would be extremely detrimental?
- ☐ YES ☐ NO Is this exceptional family member one of the rare few for whom a move out of his/her current level of services would be extremely detrimental?

I certify that the information provided is complete and accurate to the best of my knowledge.

SCHOOL OFFICIAL SIGNATURE: _____ DATE: _____

SPECIAL EDUCATION WORKSHEET

RELEASE AUTHORIZATION

SCHOOL INFORMATION

EFM'S SCHOOL OFFICIAL:

SCHOOL'S ADDRESS:

PHONE NUMBER: (Commercial)

DSN:

SPONSOR INFORMATION

I hereby authorize the above named school official or his agent to release the information in this Special Education Worksheet for the student listed below to EFM Program officials for the purpose of evaluating and determining Necessary special education needs.

_____/_____
(Name of Exceptional Family Member) (Relationship to sponsor)

SPONSOR'S SIGNATURE: _____ DATE: _____

ENDORSEMENT BY SCHOOL OFFICIAL:

☐

Special Education requirement is not applicable (If checked, DO NOT fill out the remainder of the form).

☐

This child has been assessed and does qualify for services under the Public Law 94-142/99-467/102-119.
(If checked, please complete the remainder of this form, and attach a current Individualized Education Plan (IEP) or Individualized family Service Plan (IFSP) to this form).

SCHOOL OFFICIAL SIGNATURE: _____ DATE: _____

SPECIAL EDUCATION WORKSHEET

Student's name:	Student's date of birth (year/month/day)
-----------------	--

Sponsor's name:	Social Security Number:
-----------------	-------------------------

Branch of Service:	Sponsor's address:
--------------------	--------------------

Name and address of school exceptional family member is presently attending:

CHECK APPROPRIATE BOXES:

☐ Student's educational performance is adversely affected by physical impairment that requires environmental and/or academic modification.

	Deaf		Deaf-Blind
	Hard of hearing		Blind
	Orthopedically impaired		Autistic
	Visually handicapped		Other health impaired

☐ Student manifests a psycho-emotional state (seriously emotionally disturbed) as the primary cause of Academic and social difficulties.

☐ Student's educational performance is adversely affected by speech and language difficulties.

	Voice production disorder		Dysfluency
	Misarticulation		Receptive language delay
	Expressive language delay		

☐ Student's measured academic achievement in math, reading or language is adversely affected by underlying Conditions including intellectual deficit and/or information processing and/or developmental adaptive behavior deficit.

	Generic, mild educational impairment		Mentally retarded (mild)
	Mentally retarded (moderate, severe)		Specific learning disability

Current grade level of exceptional family member.

	Preschool		Kindergarten
	First through twelfth (use #'s 1 to 12)		Greater than high school

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SPECIAL EDUCATION WORKSHEET

Special Requirements:

	Large Print		Optical aide (magnify-devices, projection devices)
	Requires Braille instruction		Is Braille proficient
	Talking books		Requires Braille material
	Requires ongoing mobility training		Requires support for independence (seeing eye dog, cane, direction ability)
	Amplification (hearing aid /assistive listening device FM systems)		Signing
	Non-oral communication		Speech and language training for hearing impaired or deafness
	Total communication		Oral communication
	Environmental adaptation (ambulation or sitting (i.e. Wheelchair))		Alternative (tape recorder, typewriter, computer, oral exams, etc)

If student requires related services, check all that apply:

	Physical Therapy		Occupational therapy
	Counseling		Audiology
	Psychological services (therapeutic)		Psychological services (diagnostic)
	Recreational services		Adaptive physical education
	Cooperative work study (job training, adapt for safety, ambulatory or health)		Vocational education
	Speech therapy		

Types of placement:

	Regular class placement with modifications		Special education resource class 10-20% of the school day
	Special education part-time class 20-50% of the school day		Special education 50-100% of the school day
	Placement in a special day school		Educational instruction provided in hospital or at home
	Placement in an early childhood preschool program		